August 19, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0730-01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is Board Certified in Neurological Surgery.

THE PHYSICIAN REVIEWER OF YOUR CASE **AGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. The reviewer has determined that EMG and NCV and DSEP/SSEP of lower extremities is neither indicated nor medically necessary in this case.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of

Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on August 19, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0730-01, in the area of Neurological Surgery. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Review of the patient's history, with date of injury ___.
2. Correspondence and notes as related to the primary physician requesting diagnostic studies in the form of electrical studies and evoked potentials, ___.
3. Imaging study reports, including a CT of the lumbosacral spine performed in September 2001 and a more recent MRI of the same area of the spine performed in April 2002.
4. Additional information included clinical reviews by ___ and ___.

B. BRIEF CLINICAL HISTORY:

The patient is a 48-year-old male with a history of low back as well as lower extremity discomfort/pain. He has previously undergone lumbar spine procedures as well as operations in an attempt to alleviate symptoms related to his work injury. However, he has persisted with symptomatology, both in the lumbosacral spine as well as lower extremities, with the right side more affected than the left.

C. DISPUTED SERVICES:

A request has been made by ___ in regards to performing electrical studies of the lower extremities.

D. DECISION:

I DISAGREE WITH PERFORMING THESE DIAGNOSTIC STUDIES AT THIS TIME, IN THAT I DO NOT BELIEVE IT IS MEDICALLY NECESSARY AS RELATED TO HIS WORK-RELATED INJURY.

E. RATIONALE OR BASIS FOR DECISION:

If there were some concern on ___ part as to a neurologic process other than his work injury (i.e., lumbar degenerative disk disease/spondylosis) contributing to his current symptomatology, then it might be appropriate to perform electrical studies. However, based on the information provided, there is no evidence to suggest the patient has any evidence of a metabolic process or other areas of his nervous system being affected and contributing to the current symptoms/signs.

There is notation within these notes to state that the patient's motor strength is normal. There is not a clear-cut defined dermatomal distribution of discomfort in his legs, although there is mention of lateral thigh discomfort on the right side. He has reflex asymmetries with diminished right knee as well as bilateral ankle reflexes. It is not entirely clear as to whether or not this is new or old. I think the likelihood of electrical studies delineating the etiology of his pain symptoms is extremely small. In addition, his imaging studies suggest the possibility of arachnoiditis which may, in fact, be a contributing factor to his pain symptoms. I do not

believe that electrical studies would delineate a specific nerve root distribution as related to this arachnoiditis. More importantly, the

issue of treatment as related to his symptoms I do not think would be affected by these studies.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 16 August 2002